Boulder

Addressing Addictive Disease in the Workforce

An Overview for Employers

EXECUTIVE SUMMARY

Millions of Americans struggle with substance use disorders (SUD). In 2019, drug overdose was the leading cause of accidental death for people under 50. Each day, we lose 130 people to opioid use disorder (OUD).

Employers play a critical role in helping workers and their families overcome this devastating chronic disease. In fact, workers in sustained recovery from substance use disorder (SUD) have even better retention and productivity than the general workforce.[1]

In this paper, we examine the drivers behind this pressing health challenge. How can employers reduce their costs while helping employees become healthier and more productive? What factors make an addiction treatment program effective?

Boulder, a leading telehealth provider of treatment services for SUD, offers insights from a team of experts in addiction medicine, clinical research and integrated care delivery models.

We help companies ensure both their employees and businesses maximize their potential and thrive.

Opioid use disorder remains a national public health crisis **with a serious impact on the workforce.**

The opioid crisis continues to escalate.

Prescriptions for opioids have quadrupled since 1999, as have overdose deaths from prescription pain relievers and heroin. Every day, there are 1,000 emergency department (ED) visits and 130 overdose deaths due to opioids.

More than half of those with OUD experience co-occurring behavioral health or substance use disorders (SUD), using alcohol or other drugs.

Employers across all industries employ people affected by addiction.

The rate of overdose among people with large employer coverage has increased sharply: a more than nine-fold increase over the past decade.

75% of adults with SUD are in the workforce. Of the estimated 15 million Americans who use illegal drugs, over 70% are employed. (NCAAD.com)

Treatment costs have exploded:

1,375% INCREASE 2011–2016

SUD pervades the workforce:

10.8M WORKERS WITH SUD

Costing employers billions:

$197B TOTAL SPENDING

$17,405 COST PER PERSON

OUD affects broad demographics, spanning all ages, genders, races, socioeconomic statuses and geographies.

Currently, individuals using heroin are slightly more likely to be white, middle-class, and live in suburban and rural areas.[2] Disease prevalence is increasing across the board: overdoses increased for both sexes, those 25–44 years old and 55+, non-Hispanic whites and African Americans year-over-year. (CDC)

More than most other chronic diseases, OUD is a social disease that often occurs in families and households, affecting both workers and dependents.

Adolescents represent the fastest growing category for OUD nationwide. There has been a surge in treatment spend for young adults on their parents' health plans, particularly with the Affordable Care Act expanding the time horizon for dependent coverage to age 26. The cost to treat 18- to 25-year-olds more than doubled from 2010–2014. (SAMHSA)

COVID-19 is fueling the next wave of the crisis.

Legislative efforts have brought incremental wins to certain states in 2018–19, but overdose rates continue to increase in most states, particularly with the impact of COVID-19. Early numbers are alarming—in a McKinsey survey (March 2020):

87% *reported elevated distress due to COVID-19 and its impact on their job*

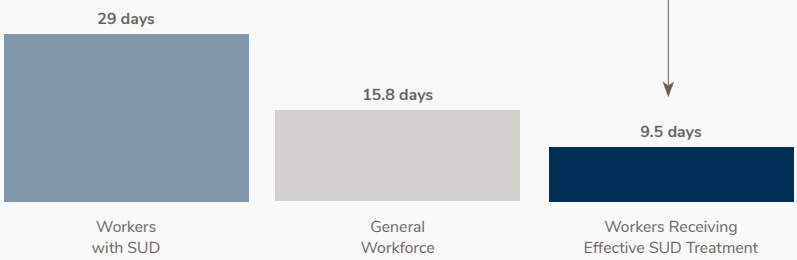
20% *reported taking prescription drugs for non-medical reasons*

15% *reported using illicit drugs*

Providing resources to assist workers with their substance use is **an important investment.**

Missed Work (days per year)

Workers with SUD miss 50% more days than their peers. Those with pain medication use miss 3x as much—6 weeks/year. (National Safety Council, 2020)



Workers in recovery who report receiving effective SUD treatment miss the fewest days of any group—even the general workforce.[3]

Employee Turnover

Workers in recovery are the least likely to leave their employers. Their turnover rate of 21% is lower than workers with no current—or prior—substance use issues.[4]

42% *of workers with OUD report having more than one employer in the past year*

75% *of employers say workers have been directly affected by opioids*[5]

Healthcare Costs

Hospital Use: Patients with OUD are 2x more likely than peers to have been hospitalized in the last 12 months and when hospitalized, stay more than 2x as long.[6]

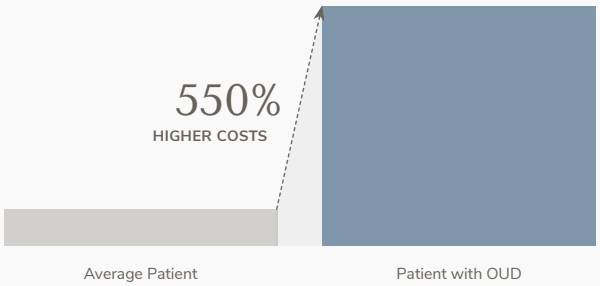
› Average hospital paid claim per day in 2014 = $2553 (Healthcare Cost and Utilization Project)

Emergency Room Use: Workers with OUD use hospital emergency services (ED) more than 4x as often as workers with no SUDs or in recovery, and 2x as much as workers with any other SUD.

Lab Testing: Toxicology testing for drug use is rampant with fraud, waste and abuse. Regulators have had to intervene as treatment clinics charge $4,000+ per test and test 2-3x per week. (NYT, 2018)

Average Annual Medical Cost per Member

Private payors' average costs in 2015 for a patient diagnosed with OUD were more than 550% higher—approx. $16,000 more per patient—than the per-patient average cost based on all patients' claims.[7]



UHC (2019) private payor industry data—opioids account for $15,000 in per-patient incremental annual health care costs (additional $1,250 PPPM) and 25% of all workers' compensation costs.

There is a clinically proven, cost-effective solution: **medication-based treatment for OUD.**

Medication treatment is evidence-based, combining the use of FDA-approved medications like buprenorphine with behavioral therapy and recovery support services to provide a comprehensive approach to treating OUD. Medication is available at most any pharmacy, stabilizes physical cravings and withdrawal symptoms, and is safe to take daily without impairing cognitive functioning.

Buprenorphine treatment reduces death from overdose, all-cause mortality, and other substance use, and improves treatment retention, social function and quality of life. Unlike residential or "detox" facilities, buprenorphine treatment can be managed conveniently at home with clinical oversight.

Addiction is a chronic condition; thus, it is not a disorder to be "cured" any more than diabetes. Most patients need medication, psychological skills for daily disease management, and social interventions, which include engaging and educating family members and loved ones to support their care.

Patients on buprenorphine for even 4 months demonstrated (compared to untreated):

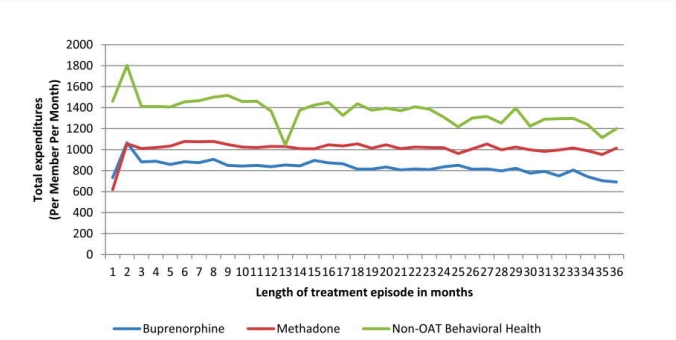
100% REDUCED DETOX UTILIZATION

82% DECREASED BEHAVIORAL HEALTH ADMISSIONS

82% DECREASED MEDICAL HOSPITALIZATIONS

60% DECREASED OUTPATIENT COSTS

Total Expenditure by Treatment Type



Clark, Robin E., et al. "Risk Factors for Relapse and Higher Costs among Medicaid Members with Opioid Dependence or Abuse: Opioid Agonists, Comorbidities, and Treatment History." Journal of Substance Abuse Treatment 57 (2015): 75-80.

Medication-based treatment is also highly affordable.

The cost of covering medication and counseling services is less than half that of no treatment: $13,578 vs. $31,035 per member per year, which translates to $2,586 per patient per month (PPPM).[8]

Innovative payment models realign incentives toward better outcomes. Perverse incentives have historically plagued the industry. Facilities are rewarded for readmissions, and outpatient centers often require frequent billable visits and wasteful drug testing. The predictable result is overutilization and poor patient experience.

A defined set of treatment services can be billed monthly at a single "case rate." This stabilizes costs, and allows providers to tailor care intensity to individual patient needs. Importantly, this remunerates providers for non-clinical interventions that are evidence-based (e.g., peer coaching, care coordination, text messaging) and promotes integration across medical, behavioral, and psychosocial dimensions of care.

Other arrangements link bonus payments to outcomes or encourage participation in "shared savings" from baseline.

Yet 90% of patients do not receive treatment, and the remaining 10% receive suboptimal care at great expense.

Access to treatment is systemically constrained.

There is a severe national shortage of providers, particularly in rural areas. Until very recently, most medical schools did not include addiction in the curricula. Primary care clinicians can prescribe buprenorphine, but must obtain a special license and training, and meet burdensome administrative requirements. At least 4 in 10 certified to offer buprenorphine are not prescribing at all.[9]

<5% OF MEDICAL PROVIDERS CAN PRESCRIBE BUPRENORPHINE

40% OF THOSE ARE NOT PRESCRIBING IT FOR ANY PATIENTS

Further restricting access, the federal government limits the number of active patients prescribers can treat, with strict legal enforcement, to between 30 and 275. One analysis found that even if every doctor who can prescribe buprenorphine did so at the maximum rate, more than half of Americans with OUD could not get medication due to the supply and demand gap. (2012 HuffPost)

Community-based providers are already overburdened.

Patients with OUD require high-touch care, coordinated across behavioral, mental and social dimensions. Most practitioners do not have the time, infrastructure, or local resources to deliver team-based specialty care. Waivered providers must remain up-to-date with complex, evolving regulatory requirements, consent to DEA inspections, and conduct regular screening and monitoring. In one survey, physicians cited concerns about medication misuse, time constraints, lack of available mental health or psychosocial support, lack of specialty backup for complex problems, stigma, resistance from practice partners, low confidence in their ability to manage OUD, and concerns about DEA intrusions as rationale for not prescribing buprenorphine.[10]

Treatment Costs

$30,000 PER MONTH FOR A 30–90 DAY RESIDENTIAL STAY

$8,183 MEAN 5-DAY "DETOX" FACILITY STAY

$36,228 MEAN INPATIENT HOSPITAL STAY FOLLOWING OPIOID/ HEROIN TOXICITY

Treatment options are fragmented, unaffordable, and not evidence-based, offering a poor patient experience.

Industry-wide, there is low adherence to evidence-based guidelines—for instance, 75% of programs do not prescribe medication. Despite decades of evidence that "harm reduction" drives cost savings and outcomes, programs remain abstinence-only and threaten to discontinue care for "non-compliance." Random, observed urine drug tests are used punitively. Many outpatient programs have rigid protocols, demanding frequent visits to the clinic, lab, and pharmacy. Stigma is perhaps the greatest barrier to treatment access, driven by misconceptions that addiction is a moral failing.

Innovative, technology-enabled treatment models have tremendous promise to make treatment more accessible, effective, and affordable.

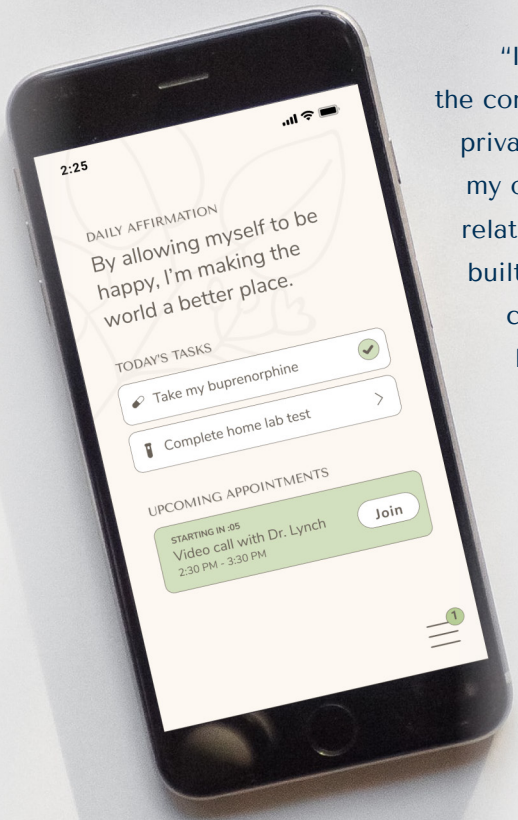
Boulder

Boulder Care is a digital clinic offering long-term support and evidence-based telehealth treatment for substance use.

Our program is designed by addiction medicine specialists and people with lived experience of recovery. By reducing the barriers to initiate and continue treatment, we drive clinical and functional outcomes unparalleled in the addiction treatment industry.

Our innovative telehealth platform allows us to reach patients privately anytime, anywhere via smartphone. We deliver care through secure video and messaging, and provide patients with a broad suite of recovery services.

Our program is grounded in harm reduction and unconditional support. Dedicated Care Teams collaborate across medical, behavioral, and psychosocial dimensions of recovery to help patients succeed on their own terms, wherever they are in their journey.



"I love Boulder; the convenience, the privacy of being in my own home, the relationship I have built with my peer coach—it is all life changing."

—BOULDER PATIENT

Dedicated Care Teams deliver customized treatment plans.

Board-Certified Addiction Medicine Specialists develop clinical guidelines and oversee care

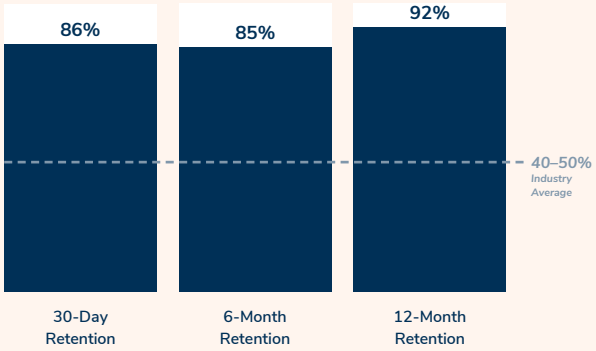
Clinicians prescribe evidence-based medication for OUD and AUD, and manage co-ocurring health conditions

Care Advocates offer expert care coordination and navigation around scheduling, insurance, pharmacy issues, and more

Peer Coaches with lived experience of recovery guide patients in setting goals, tracking progress, and accessing local resources

Boulder has demonstrated exceptional outcomes.

Retention in Treatment



Participant Satisfaction

93 NET PROMOTER SCORE

Learn more at www.boulder.care, or email us at partners@boulder.care

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